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CLINICAL MEDICINE

ORIGINAL ARTICLES

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AUTHORITATIVE INDEPENDENT PRACTICAL

DECEMBER 1947

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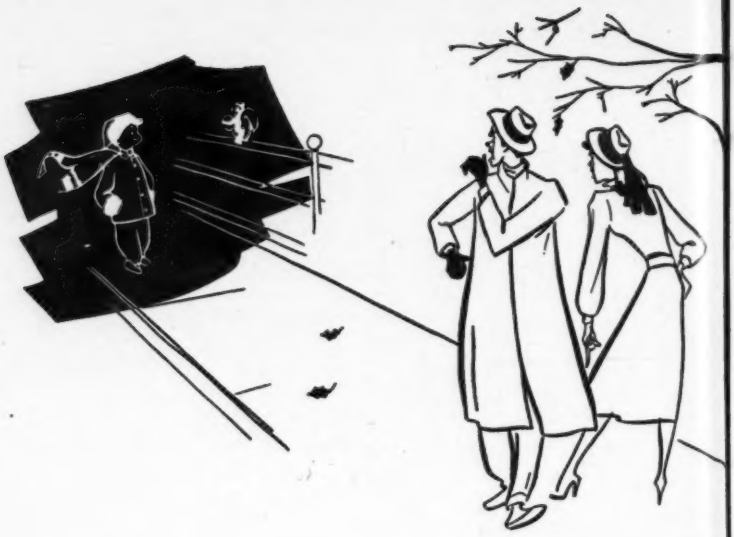

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Seminal Vesiculitis

By PAUL L. SINGER, M.D., *Phoenix, Arizona*

A GENERATION ago Belfield referred to the infected seminal vesicles as the "pus tubes of the male." The era then lacked many therapeutic agents that have since been developed and emphasis on newer things has relegated this entity to the background, until now the medical lecturer in schools and the medical writers barely mention disease of the seminal vesicles. However, *the largest group of urologic diseases that the average practitioner sees are comprised of just these so-called minor diseases of the prostate and seminal vesicles.* The diagnosis of disease of these accessory sex glands is so seldom made as to be out of all proportion to the number of cases we do see once the disease is kept in mind.

The quadrupedal posture of our forbears favored dependent drainage from the accessory sex glands, but the erect posture and habit of dorsal decubitus for sleep places the glands below the level of their ducts, with resulting stagnation and congestion. The vesicles lie above and to the side of the prostate gland, in close relationship to the vas deferens and the ureters. (Fig. 1)

Palpation of the Vesicles

The exploring finger through the anus can just reach the lower ends of the vesicles, but by having the patient assume a reverse extreme lithotomy position at the edge of the table and by spreading the buttocks wide, as well as depressing the perineum with the flexed fingers the entire extent of the seminal vesicles can be reached. The *normal vesicles cannot be palpated,* but steady pressure will yield the characteristic "casts."

The acutely inflamed or chronically indurated vesicles stand out as thickened cords just under the rectal mucosa. (The prostate and vesicles are separated from the rectum by Denonvil-

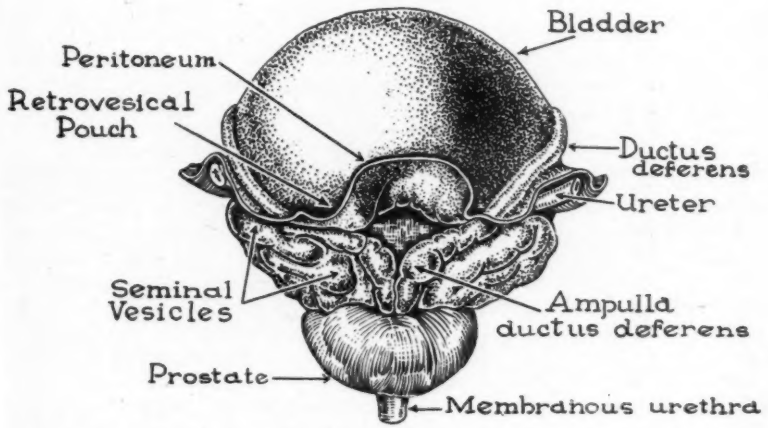

Fig. 1. Anatomic relationships between the prostate and seminal vesicles.

lier's fascia only). The upper pole of the vesicles is close to the pelvic peritoneum (Fig. 2), and inflammation can spread to produce peritoneal irritation, a local peritonitis, or even a pelvic abscess. The perivesical loose connective tissue encircles the lower ureters as well as the vas deferens. These various anatomic relations are important to explain the radiation of pain and the involvement of the juxtaposed organs in disease of the seminal vesicles.

Physiologically the seminal vesicles are not a storehouse for sperm cells, as is the urinary bladder for urine. In various species of animals the seminal vesicles are absent (carnivores and marsupials). The chief function of the vesicles is unknown. Since there are no secretory glands in mucosa, the secretion must be chiefly matrix obtained from desquamated cells. Sperm cells are found in variable numbers, but not sufficient to justify considering the vesicles as stores of sperm. It is true that injection of the vas deferens in the scrotum toward the head will show the dye in the vesicles before passing into the ejaculatory ducts, but never is sufficient material found to account for the number of sperm cells in an ejaculum. While in various species of animals various functions are ascribed to the secretion, so far little additional information has been obtained in men.

Prostatic Massage

The term "prostatic massage" is an unfortunate one, since the maneuver is not intended as a massage of the prostate to stimulate circulation or to relax spasms as would massage in other parts of the body, but to empty out the contents of the prostate and thus force open the closed, blocked or tight prostatic ducts. The term used should be "prostato-vesicular stripping," since the movements are designed to do just that. The good operator unconsciously empties the vesicles, but the average practitioner sticks to the term "prostatic massage" and fails to reach above and to the lateral side of the prostate to empty out the vesicles. Hence the procedure is worthless unless properly performed. The pressure necessary to empty out the ducts is equal in weight to about twelve pounds.

Massage should be gently done, and the gentleness should start before introducing the finger into the rectum. The touch of the finger on the anal skin causes a temporary spasm of the sphincter; here a few gentle strokes on the external sphincter lead to relaxation of the sphincter and considerably less discomfort on the passage of the finger. Pressure over the midline should be avoided until the last stroke or two, because the urethral area, including the verumontanum is the most sensitive area.

Chronic prostato-vesiculitis is now actually an occupational disease, found with great regularity in comparatively young men who drive automobiles, trucks, trams, and busses for many hours each day. The causation is the constant pressure on the perineum, lack of leg exercise facilitating circulation, and the usual concommitants of irregular sex life and alcoholism. The combination of the above factors leads to congestion, stagnation, and subsequently to prostato-vesiculitis.

Acute Vesiculitis

The acute form of prostato-vesiculitis is a more or less severe acute infection with marked symptoms of severe pain, tenesmus, fever and chills, usually following gonorrhea, instrumentation, or general sepsis. The diagnosis presents few problems, and the treatment is simplified by the new effective bacteriostatic drugs, penicillin, sulfonamide, and streptomycin, and in the case of pus formation, by surgical incision and drainage.

Chronic Vesiculitis

Chronic prostatic and vesical infection present more obscure symptoms, many of which do not point to the site of infection. In these cases, the patient may present one or more major complaints, and only questioning will elicit the other, more classical symptoms. Emphasis on the presence of a *urethral discharge* during war service has made many young men report promptly with that as the sole complaint. There may be itching and burning in the meatus or urethra, frequency and burning on urination, and heavy phosphaturia which sometimes is so heavy as to enable the patient to collect a handful at each morning voiding.

Symptoms

Pain in the lower back, perineum, suprapubic area along the course of the spermatic cord, in the testes, or in the rectum may be complained of alone or in combination.

Sexual symptoms include loss of erection, painful ejaculation, frequent nocturnal emissions, hemospermia, ejaculatio praecox, and at times, complete impotence.

Neurasthenic symptoms are common. The patient complains of vague pains, headache, dizziness, apprehension, restlessness, insomnia, and a marked egocentricity, with minute self examination of all the sensations he is capable of.

Pains may be referred to the ureters. In these cases there is acute renal colic, due to inflammation of the juxtaposed ureters. These "phantom stone" cases never pass a stone, and the usual explanation of intravesical disintegration is offered.

Spermatic Colic

One of the most dramatic and severe manifestations of seminal vesiculitis is spermatic colic. This episode is initiated by a steadily increasing pain located in the lower abdominal quadrants, left or

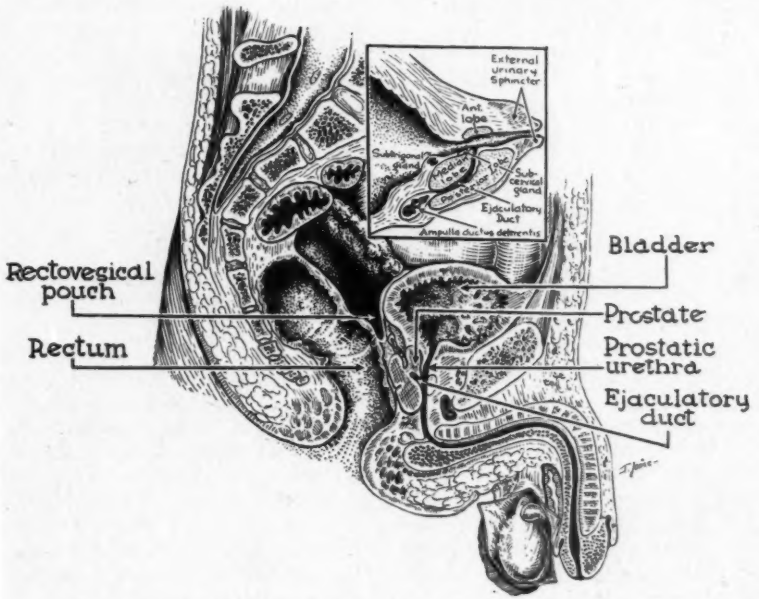

Fig. 2. Anatomic relationships important in disease of the seminal vesicles.

right, and radiating to the testis of the involved side. The sensation is that of a vise being clamped down on the testis. If the pain is severe enough it may radiate to the groin, loin, and the entire abdomen. There may be severe pain in the perineum and rectum, with the sensation of a severe urge to defecate. Pain usually starts at night following an erection. There is usually partial urinary retention, or if the patient is able to void, painful urination and a marked reduction in caliber. The pain is steady and constant, colicky in nature and is not relieved by small doses of sedative. Antispasmodic drugs work only for a short while. The urine shows an occasional red blood cell. There is occasional abdominal distention, nausea, or vomiting. Flat plate of the abdomen or X-Ray, of course, shows no renal calculus. The usual diagnosis is that of "Phantom Renal Stones." The patient undergoes cystoscopy without relief. Ureteral catheterization shows no obstruction, and the urine from the renal pelvis shows no blood cells.

The diagnosis is made on a history of irregular sex life, chiefly coitus interruptus, excessive and prolonged masturbation, or excessive mental stimulation from sex pictures and books. The onset of the pain at night and not related to vigorous activity is significant. The presence of pain in the groin and testes at the onset instead of pain in the renal area is important. Rectal examination shows marked congestion and engorgement of the seminal vesicle involved and the *pain is made worse and reproduced in detail by pressure with the rectal finger.*

The treatment consists of an immediate and a long range regimen. The immediate therapy includes hot packs to the suprapubic area, sitz baths in warm water for fifteen minutes at a time. The patient is encouraged to urinate while sitting in the bath tub and is not to be catheterized. Medication should include large doses of antispasmodic drugs and as a last resort morphine with atropine. The acute attack lasts in proportion to the abuse and duration of the abuse to the accessory sex glands and may extend from fifteen minutes to two or three days. The long range treatment includes vigorous prostato-vesicular strippings and, even more important, a rigidly normal sexual hygiene.

Urethral Smear

In the direct diagnosis of seminal vesiculitis the history, as mentioned before, is of significance. Before rectal examination is performed, the secretion from the urethra should be examined, if present, or have the patient bring in the morning smear, if only a morning drop is reported. The preponderance of mucus in the smear merely indicates hypersecretion of the urethral and Cowper's glands. The presence of large numbers of desquamated epithelial cells with some pus shows chronic prostatic and vesicular secretion, and a purulent discharge shows extraneous infection, or an acute flare-up of a chronic prostato-vesicular or posterior urethral infection, or infection in one of the urethral glands, or a urethritis from over medication, nonspecific infection, and so on. The search for bacteria, once acute gonorrhea and trichomoniasis is ruled out, is useless, and leads to false interpretation, since the normal urethra lives in symbiosis with hosts of bacteria of non-pathogenic nature ranging from gram positive saprophytes to acid-fast smegma bacilli.

The examination of two or three glasses of urine is impressive to the patient and is of some questionable assistance to the examiner. Shreds in the various glasses mean merely that there is either mucus, pus, or desquamated cells in the urine, but as to diagnosing the origin of the shreds by the glass in which it is found is rather inaccurate and unscientific. The patient should retain some urine in the bladder for final voided specimen.

The rectal finger yields the finding of the status of the prostate and the vesicles, and the expressed secretion diagnoses the condition of each. The presence of casts indicates vesicular secretion, as does the presence of sperm cells. If no secretion can be expressed, the patient should then void, and the centrifuged urine will show the microscopic findings. The amount of secretion expressed depends on the pressure employed, the patency of the ducts, the elapse of time since the last ejaculation (either active sexual or nocturnal emission), patency of the bladder sphincter and the actual contained capacity of the prostate and vesicles.

Normal secretion contains a clear matrix, with innumerable minute globules of globulin, nucleoproteins, crystals of lecithin, mucin and cholesterol, occasional sperm cells, mucus, and an occasional white cell, A pus cell count over 25 per high power field, especially in clumps, is pathologic. A wetdrop should be checked for trichomonads. The smear should be stained for gonococci and other bacteria. If culture of the secretion is to be made, the patient must have instilled a bladder full of mild antiseptic, which he voids before prostatic massage. The glans is then thoroughly scrubbed with soap and water, and the secretion must drop clear into the culture medium. Again the interpretation of bacterial culture must be correlated with other facts, and of itself is misleading, except, for gonorrhea.

In the differential diagnosis of prostato-vesiculitis, abdominal conditions must first be ruled out. The referred pain along the course of the spermatic cord often simulates acute appendicitis. This has been repeatedly brought out recently, but sufficient emphasis cannot be placed on the importance of correct diagnosis.

There may be a few red blood cells with the acute ureteral colic, due to the transudation of red cells from inflamed ureteral wall. The presence of red cells is not the exclusive manifestation of calculus as is so often concluded on urinalysis. Ureteral colic may be due to obstruction from edema as easily as from a stone or acute angulation.

Treatment

The treatment of chronic infection of the seminal vesicles must be directed towards eradication of the congestion, recovery of the walls, and prevention of recurrence. Vigorous prostato-vesical stripping not oftener than five days apart is the best procedure. In case of severe pain on pressure with the rectal finger, the stripping should be gentle until the patient is accustomed to the pain. Flare-up of an acute inflammation, or epidymitis precludes stripping for a few weeks. The best urethral flushing following massage is a complete voiding of a full bladder, and the patient is instructed to report for treatment with a full bladder. Even the most meticulous technic will eventually introduce infection along with the bladder irrigating solution. Urethral instrumentation, except for stricture or cryptitis, is contraindicated, as is the fulguration of the verumontanum, or the instillation of silver nitrate solution into the posterior urethra.

Sexual activity should be limited to not more than one coitus weekly, and if the coitus is followed by pain, lassitude or malaise, it should be interdicted completely. After recovery of the sex glands the patient is to be instructed in normal sexual hygiene, with correction of prior bad habits. The practice of coitus interruptus, incomplete erethicism, prolonged sexual play, the viewing of sex pictures and the reading of sexy books must be stopped.

Alcoholism is usually found in severe cases to be a factor, probably through its effect on the libido. Hence, during the treatment, reduction in intake or complete cessation is to be recommended.

39 W. Adams St.

Fluorescent Microscopy of Fluid Movements in Living Tissue

By RUDOLPH KELLER, PH.D., *and* BARNEY V. PISHA
Robinson Foundation, Inc., New York, N. Y.

UP TO the present time, the observation of living tissue in ultraviolet light has not been fully exploited. During the year 1926, F. P. Fischer modernized the method of examining living tissue in ultraviolet light by using electropositive and negative dyes, particularly uranine (positively charged in protoplasm) and trypa-flavine (negative). Later E. Singer (1936) and M. Haitinger (1937) used positive and negative dyes simultaneously. The reason for these methods is to follow the movement of colored fluids in very great dilutions. The ordinary method of vital staining using daylight illumination shows accumulation of the dyes or solutions only in great concentrations.

Transparent animals or plants are stained in the usual way with very dilute daylight dyes such as the negatively charged neutral red, methylene blue, toluidine blue, alizarin and the positively charged eosin Y, congo red, and acid fuchsin in acid. After the staining is complete, they are washed and placed into a solution of aesculine 1:1000 for one half minute. Then they are washed two or three times and placed into rhodamine B for three minutes. After being stained with Rhodamine B they are again washed two or three times. The dye solvent in all cases was tap water. Upon examination in ultraviolet light, the preparations appear in two fluorescent colors which in turn illuminate the neighboring structures that are stained with the daylight dyes.

With this method we have been able to observe the action of the stomach and the nephron of transparent animals in a normal state without resorting to surgery or narcosis and view the production of acid in these organs as well as in the vacuole of plants.

Our observation in ultraviolet light reveals that in the living cells most solutions of opposite charge are continually moving in two opposite directions; the extracellular group (identically with the biologically positive half of the lyophile series of Hofmeister and Spiro) to the electronegative structures and the negative half to the positive structures. It was first shown by E. Wertheimer in 1925 that the antagonistic groups are wandering in opposite directions in the skin and lung membranes of frogs. With ultraviolet light we observe that this is not only a peculiarity of the frog skin and lung membrane, but seems to occur in most tissue and fluids thus far examined.

In the transparent leaves of *elodea canadensis*, the filtered light rays (4500 to 3000 Ångströms) falling upon the thin alkaline protoplasmatic film of the leaves produces acid in the inside of the vacuole, and alkali in the surrounding water by drawing off alkali from the vacuole to the outer water. Fluorescent indicators were used to check the gross pH change. This action is similar to that observed by Montgomery and Pierce in Richards' laboratory where they found urine being acidified by the withdrawal of sodium bicarbonate from the lumen of the tubules to the surrounding tissue water and serum in the nephron of nocturus.

Wherever possible, controls were set

up using standard daylight illumination technique.

Discussion

This is a fine statement of microscopic practices that I have seen used, in the early beginnings, in Europe. Their work is well-integrated into the literature.

Dr. Keller has demonstrated, I think successfully, that potassium is not always in the cell and sodium without, but that this varies in different tissues.

The ultraviolet method is deserving of more attention in the United States and deserves a larger audience.—A. H. Steinhaus.

Abdominal Incision Suture: Closure of "Difficult" Cases

Suturing the peritoneum of a patient who is only partially relaxed may be aided by temporary approximation sutures.

Fig. 1 illustrates the placing of such strong sutures through the full thickness of the abdominal wall about 1½ inches from the edge of the incision, engaging the two lips of peritoneum and emerging on the opposite side, beyond the incision. Several sutures may be so placed, depending upon the length of the incision.

Fig. 2: Forceps grasp the ends of the sutures. The tissues enclosed by the sutures are pushed together, until the edges of peritoneum are in contact, then the tissues are prevented from sliding back, by additional forceps which grasp the sutures where they enter the skin.

Fig. 3: Suture of the peritoneum and fascia then can be accomplished without tension, following which the temporary sutures are withdrawn.—NICHOLAS A. SCHNEIDER, M.D. to *Southern M. J.*, Sept. 1946, *(Clinical Medicine* illustrations adapted from original).

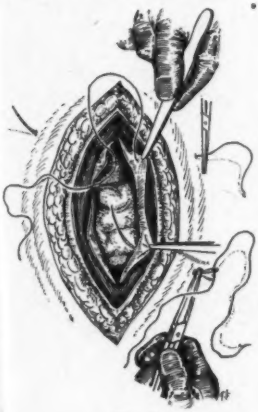

Fig 1

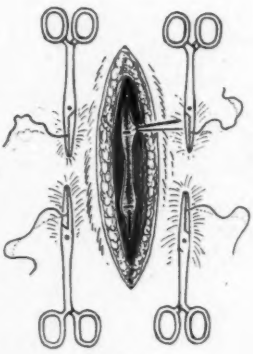

Fig. 2

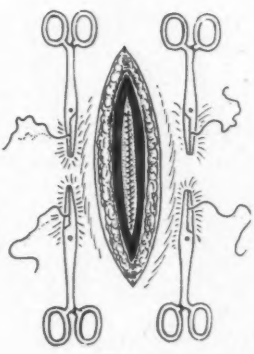

Fig. 3

Clinicopathologic Conference (Case 10)

A HOUSEWIFE 58 years of age, had had attacks of asthma for 25 years, without known etiologic factor. Examination: Labored, wheezing respiration with prolonged expiration; anteroposterior diameter of chest increased; very resonant lung fields; diaphragm depressed and chest expansion decreased; temperature 99° F., pulse 110, respirations 22, blood pressure 160/110. (Fig. 1)

Red blood cell count 5,360,000, hemoglobin 15 Gm., white cell count 10,950 with 62 percent neutrophils and 9 percent eosinophils; urine normal; chest x-ray; bright lung fields, low diaphragm, prominent pulmonary markings throughout the chest, particularly at bases. The heart was slightly enlarged to the left. Orris powder caused a 2 cm. skin wheal; chicken feathers, ragweed and goose feathers caused positive, though smaller skin reactions.

Course

For two years she carried on with aminophyllin, adrenalin and potassium iodide and treatment for recurrent attacks. There was never any evidence of heart failure, the chest films showed little change and the electrocardiogram was normal (Fig. 2)

Final examination: After 2 weeks of more frequent and more severe attacks, she was admitted in moderate respiratory distress; slight cyanosis; expiratory wheezes and rhonchi over both lung fields, more numerous on the left; heart sounds faint; plumonic second sound greater than the aortic; neck veins not distended; no enlargement or tenderness of the liver or ankle edema. 10 cc. of aminophylline intravenously relieved her and 24 hours after admis-

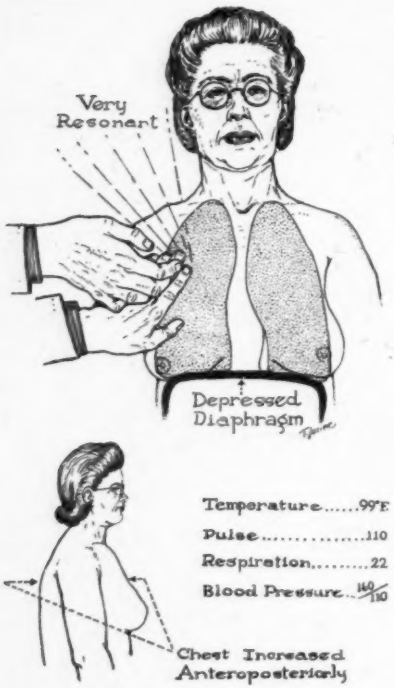

Fig. 1. Examination

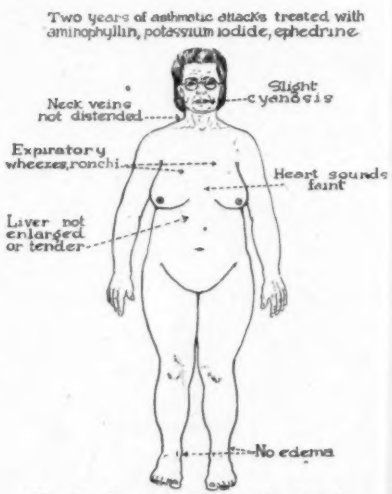

Fig. 2. Course and Final Examination

sion, while she was dressing to go home, she suddenly became much worse. When examined a few minutes later, she was sitting in a chair, doubled forward and breathing in short grunts. The usual asthmatic rales were heard at the right base posteriorly but breathing was very shallow and she was extremely cyanotic (Fig. 3). Oxygen was given by mask and artificial respiration begun as the breathing was reduced to an occasional gasp. There were several convulsive movements of the face and she died 10 minutes after the onset of the attack.

Discussion

Clinical diagnoses included bronchial asthma, pulmonary embolus, pulmonary emphysema and hypertension. The cause of the sudden death was considered to include (1) a bad attack of asthma due to exertion of getting dressed or emotional reaction at the thought of going home, but ten minutes was a very short time for a fatal attack of asthma, (2) massive pulmonary embolus which may have been dislodged as she was getting dressed, from a thrombus in the femoral or pelvic vein, 3) coronary thrombosis which however would have caused pain, (4) spontaneous pneumothorax which should have caused pain, a shifting of the heart to the opposite side and a widening of the intercostal spaces on the affected side, (5) massive collapse of the lung due to sudden obstruction of the bronchi, to pulmonary infarction, to infection, to an allergic cause or to nervous stimuli, with a shift of the heart to the affected side, (6) death following administration of morphine to asthmatic patient.

Your diagnosis ———————

Necropsy

The usual asthmatic has balooned lungs, which meet in the midline, covering the heart and which do not collapse when the chest plate is removed. The bronchi are filled with mucous plugs, usually in the medium sized bronchi, their walls are thickened, and mucous glands are hypertrophied; the basement membrane is thickened and there is lymphocytic and eosinophilic infiltration of the bronchial walls. All these were found in this patient plus air pressure in the left chest and the left lung pressed to the right against the spine. The left lung showed several emphysematous blebs, but no definite rupture or tear could be found. The spontaneous pneumothorax was apparently the immediate cause of death.

Importance

Spontaneous pneumothorax is a very rare complication of bronchial asthma but it does occur in other persons ap-

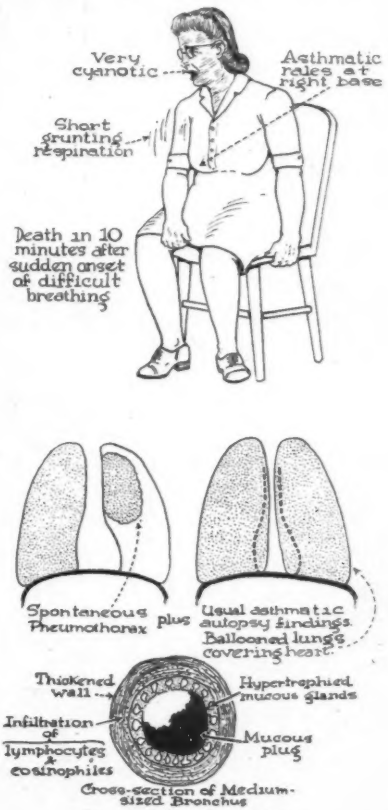

Fig. 4. Necropsy Fndings

parently in perfect health. The heart is pushed away from the affected side. The patient can be readily saved by inserting a needle between the ribs of the affected side of the chest and permitting release of the air under pressure.

It is only too easy to ascribe sudden deaths to "heart failure" instead of examining the patient promptly and intelligently. In some cases, sudden accumulations of pleural fluid have led to cyanosis. Examination here will indicate the flatness of liquid in the chest and the displacement of the heart away from the affected side. Again, the simple insertion of a needle will confirm the diagnosis and relieve the patient.—Editor.

(The above conference was presented at the Massachusetts General Hospital and published in *New England Journal of Medicine;* this brief summary was made for our physicians and our original illustrations are by T. Lozier.—Ed.)

Severe Asthma

A patient with severe asthma can best be treated in the hospital. Patients who are apprehensive, or panic stricken by their dyspnea respond favorably to new surroundings. The hospital room should have no rugs, drapes, stuffed furniture, feather pillows or mattress. Dust proof covers should be available for pillows and mattresses. Kapok pillows are not satisfactory, but rubber foam or air pillows may be used. the daily cleansing of the patient's room is best done with a damp cloth. No sweeping should be done. If hay fever is associated, a pollen filter in the window is most important. Transoms, doors and other windows in the room should be kept closed when the pollen filter is being used.

If bronchitis is associated, it will often subside more quickly if the room is free from drafts, smoke, and furnace and other fumes, and kept at an even temperature. The use of an oxygen mask is of real help.

Aminophylline given twice daily in doses of 3¾ grains intravenously is of value. It may be given in 250 cc of 10 or 20 per cent dextrose solution. Aminophylline relaxes bronchial spasm in the asthmatic patient.

Prescription 1 is used when bronchitis is a primary problem. Prescription 2 is used when there is an excessive amount of secretion and when allergic factors and allergic rhinitis are associated. The expectorant containing iodide is given for the bronchitis and should be used continuously when asthma is troublesome or when asthma is threatened as when convalescing from acute bronchitis. If there is evidence of actual tuberculosis, iodides should not be given.

For children, a saturated solution of potassium iodide is more easily administered.— L. E. PRICKMAN, M.D. (Mayo Clinic) in *J.A.M.A.*, May 4, 1946.

Expectorants: Two prescriptions containing iodides are:

℞ 1.
Potassium iodide ..... 17.5 grams
Fluidextract of lobelia. 1.5
Fluidextract of hyoscyamus 1.5
Glycerin 26.00
Simple elixir in sufficient quantity to make 250.00
Directions: One teaspoon in water three times daily after meals.

℞ 2.
Potassium iodide ..... 10.00 grams
Sodium iodide 10.00
Tincture of belladonna 20.00
Tincture of hyoscyamus 20.00
Tincture of lobelia 20.00
Fluidextract of grindelia fluidextract syrup of tolu balsam, each in sufficient quantity to make 250.00
Directions: One teaspoon in water three times daily after meals.

Bronchoscopy in Early Diagnosis of Lung Carcinoma

By ARTHUR Q. PENTA, M.D.*
Schenectady, New York

ASIDE from the removal of aspirated foreign bodies in lungs, for which no procedure other than bronchoscopy is worthy of a moment's consideration, the profession at large has not realized that the greatest value of the bronchoscope is in diagnosis. A recent statistical survey of the patients admitted to several of the large bronchoscopic clinics in this country revealed that only 2 per cent of the admissions were for the removal of foreign bodies. As the late Dr. Howard Lilienthal, one of the great teachers of thoracic diseases, has often stated: "The scope of bronchoscopy has rapidly widened from the mere extraction of foreign bodies to the diagnosis and treatment of many pulmonary diseases. One of the most important applications of bronchoscopy is in the diagnosis of carcinoma of the lung.

Carcinoma of the lung is a relatively common disease and is responsible for approximately 10 per cent of all cancer deaths. This occurrence is frequent enough to warrant the attention of the medical profession toward establishing an early diagnosis. In view of the rapid progress made in the field of thoracic surgery, an early diagnosis will result in a greater operability of this condition which in the past had 100 per cent mortality. The increasing number of patients to date, surviving a five year period following total pneumonectomy, should serve as a stimulus to the medical profession, to diagnose cancer of the lung in its early stage. Bronchoscopic examination with removal of tissue for histological study is by far one of the most important diagnostic procedures available.

Symptomatology

The symptoms produced in primary carcinoma of the lung will depend to a great extent on the degree of bronchial obstruction. The most important early symptom is a dry, hacking cough accompanied by a slight bronchial wheezing. Physical examination during this early stage may reveal a few coarse moist rales and asthmatoid-like wheezing over the involved pulmonary area. Roentgenographic studies of the chest during this stage may be entirely negative since the tumor is not large enough to cast a shadow. At this time the patient usually seeks medical advice because of the troublesome cough and wheezing. It has been the author's experience, when obtaining a history of these patients referred for bronchoscopic examination, that they invariably had been under symptomatic treatment for a long period of time and had shown no improvement in their condition.

It has been repeatedly stated by that great teacher of bronchoscopy, Dr. Chevalier Jackson, that "all that wheezes is not bronchial asthma." The importance of this one symptom alone cannot be too strongly emphasized. In a series of 44 cases of bronchial carcinoma, bronchoscopically examined by the author during the last five years, it was astonishing to learn that fifteen of the patients, because of recent wheezing, cough, and slight dyspnea, had been previously treated for bronchitis

*From the Department of Broncho-Esophagology, Ellis Hospital, Schnectady, New York.

or bronchial asthma. Every patient, particularly of the cancer age group, presenting this chain of symptoms, should immediately be x-rayed and should have the benefit of a diagnostic bronchoscopy. The appearance of blood streaked sputum or frank hemoptysis are also frequent early symptoms and are usually due to the trauma of coughing and ulceration of the tumor mass. Pain, as in other malignancies throughout other parts of the body, is definitely not an early symptom. In a recent study of the subject, Overholt calls attention to the fact that approximately three-fourths of all primary lung tumors are situated in the major bronchi so that they are within range of bronchoscopic vision. His findings are in complete agreement with C. L. Jackson, who in a recent article stated that bronchoscopic biopsies will be positive in 75 per cent of the cases of bronchial carcinoma. In the series of forty-four cases personally examined by the author during the past five years, a positive biopsy was obtained in 32 cases. This high percentage of positive biopsies is definite evidence that bronchoscopic examination plays an important role in the diagnosis of lung carcinoma.

For the purpose of clinical study, Overholt divides the clinical course of primary lung carcinoma into the following divisions: (1) the stage before bronchial occlusion, (2) the stage of bronchial occlusion, and (3) bronchial occlusion with secondary infection. The physical signs to be found in the examination of the chest will naturally vary with the degree of the bronchial obstruction. It is always to be remembered, however, that the first symptoms of bronchial obstruction, regardless of the cause, are wheezing and coughing.

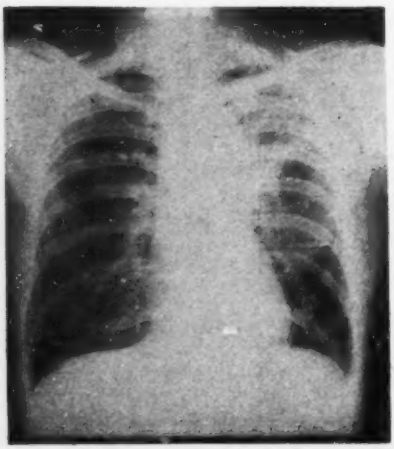

Fig. 1. Radiography of male patient age 42, showing infiltration arising from upper left hilar region and involving the upper lobe. Had been undergoing treatment for bronchitis and suspected tuberculosis. Because the cough, wheezing, and expectoration had become progressively worse, he was advised to undergo bronchoscopic examination. Bronchoscopy revealed a small tumor mass involving the left main stem bronchus. The histological report was a grade III, epidermoid carcinoma. He refused operation and three months later developed a complete atelectasis with beginning suppuration (Fig. 2).

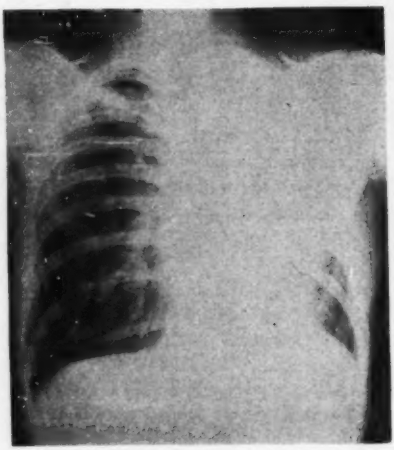

Fig. 2. The same patient three months later. Radiography now reveals a complete bronchial obstruction with atelectasis. Patient expired two months later. Post-mortem examination revealed an extensive bronchogenic carcinomatous involvement of the left lung with superimposed pulmonary suppuration.

In the differential diagnosis one should always consider the possibility of a neoplasm as the causative factor.

That bronchoscopic examination is not a hazardous procedure is best illustrated by the fact that during the past years, during which time over 1500 cases have been personally examined by the author, more than 90% of the cases examined or treated were handled as outpatients.

The following report of two cases of primary carcinoma of the lung, both diagnosed by bronchoscopic examination, will serve as an illustration in reemphasizing the delay and the advantage of an early diagnosis.

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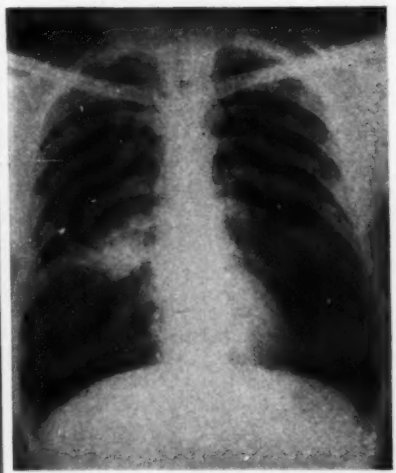


Fig. 3. Radiograph of male patient age 44 revealing a shadow with surrounding infiltration in lower portion of right lung. Because of a small hemoptysis he consulted his family physician who immediately advised bronchoscopic examination. Bronchoscopy revealed a small tumor mass arising from the posterior wall of the right main stem bronchus. Histological report of tissue removed was an epidermoid carcinoma grade II. Patient consented to undergo operation and the entire right lung was removed by Dr. Ralph Adams of Boston, Massachusetts.

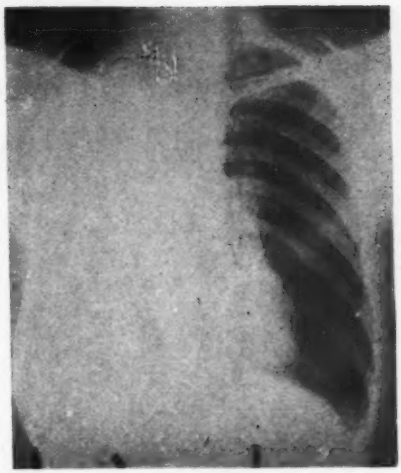


Fig. 4. Radiograph of patient taken four years later. For past two years patient has been able to engage in light work and is enjoying good health. The dense homogeneous shadow of the right side is typical in appearance of post total pneumonectomy operations. It is caused by thickened pleura and fibrinous organization.

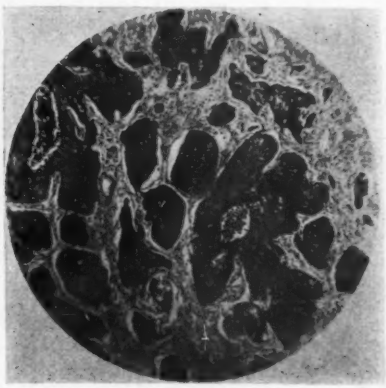


Fig. 5. Histological section from lung removed showing epidermoid carcinoma.

Asthma and Hay Fever: A Different Concept

By WILLIAM GRANT LEWI, M.D.
New York City

ROSE COLDS, hay fever and hay fever asthma responded well to my treatment which I first employed many years ago (1912). Of seven cases with active symptoms, all but one showed either a decided alleviation of symptoms or were completely relieved within two weeks.

Three of these patients had asthma as one of the seasonal symptoms. It was the rapid disappearance of this symptom that was so gratifying, to me as well as to the patients. The asthma disappeared, nor did it recur throughout the season. Some of the other symptoms did persist but in a modified form.

I speculated on the possible value of this same method of treatment in cases of real bronchial asthma; the type of asthma that was present at all seasons and bore no relation to pollination.

I began seeking and treating cases of bronchial asthma and was again gratified at the early lessening of symptoms, with continuing improvement; and being able to discharge most of these cases treated during this first period after three to four months, entirely free of all symptoms.

All of these events occurred in a moderate sized city where one could keep in touch with patients, and seeing these former patients years later, I found that the relief afforded had proved complete and permanent.

I have continued to employ this form of treatment ever since 1912 for the relief of asthma, hay fever and rose cold as well as other conditions arising from the same basic cause. As a result of many years of observation, I have reached certain conclusions which are justified by the facts.

New Concept

First: That the conditions known as rose cold and hay fever are *not* due primarily to the pollens. They are the result of an abnormal condition of the mucosa of the upper air passages. Because of this abnormal condition of these parts, the pollens act as irritants to those who are susceptible and the symptoms develop, while leaving other persons unaffected.

Through the use of this treatment I have been able to render normal the condition of the parts affected and they become immune to the irritating effects of the pollens; and symptoms do not develop.

Second: That asthma is no more due to allergies than are the allergies due to asthma, but both are due to *dysfunctioning of the sympathetic nerve system.*

The same is true of hay fever, rose cold and kindred conditions. In innumerable instances I have seen that as the symptoms of asthma became lessened under this treatment, the susceptibility to foods, odors and emanations — the allergens — became lessened; and that foods that previously had caused immediate acute attacks could be partaken of in moderate quantities with impunity; and that when finally the asthma had disappeared entirely, the so-called allergies were no longer in evidence.

When I first realized that dysfunctioning of the sympathetic was the basic cause of asthma, I thought I had made an original discovery; but a search of the literature revealed that as early as 1833, Roch and Sanson had written that many cases of asthma were of nerve origin; and since then many writers, including Osler, have written to the effect

that asthma was due to dysfunctioning of one or another part of the nervous system, but no one ever suggested a means of correcting these misbehaving nerves. Details of these writings are part of one of my previous papers, in *New York State Journal of Medicine*, June, 1926.

Of more than 1600 cases of asthma and kindred conditions that have been treated by this method during the past thirty-five years, a little over 60 per cent have been completely and permanently relieved of all symptoms and an additional 30 per cent have been materially benefitted (practically all asthma cases in this 30 per cent have been able to discontinue the use of potent drugs, where these had been resorted to for temporary relief).

I endeavored, time and again, to have this method of treatment investigated and evaluated under critical medical observation, chiefly as to its effectiveness in asthma. I have made formal application to twenty-four organizations, all formed for the study of new methods in medicine and their endorsement when found worthy, as well as to innumerable hospitals and cinics. None would supervise such a demonstration.

This is the old story (remember Jenner?) of derision, skepticism and neglect of new concepts in medicine rather than a willingness to investigate.

The suffering of approximately a million and a half people in the United States having asthma would have been alleviated in varying degrees if this method of treatment had been investigated when it was first announced twenty-five years ago, and had been accepted, as I am confident it would have been. And, if this treatment were now generally available it would be the means of bringing complete relief to most of these sufferers, and of ameliorating the condition of another large group.

Treatment

The method of treatment employed to achieve these results is the production of hyperemia, by means of the higher frequency electric current, applied by means of a vacuum or conductor-filled electrode, applied over the superficial portion of the sympathetic, along the spinal column. The hyperemia produced is not only of the surface but penetrates to the deeper structures.

The current employed to achieve these results is unique. It is unlike any other current, either commercial or therapeutic. It has a frequency of 4,000,000 cycles and, as delivered to the patient, has an amperage of from 250 to 300 milleamperes (1-4th to 3-10th of an ampere, according to the electrode used).

To identify this current I have named it. The Syn-Acro Current, a name derived from the two Greek words "Sychnoteros" meaning "higher", and "Acroteros" meaning "frequency".

The application of this current by means of a vacuum or conductor-filled electrode is accompanied by a sensation of heat and a "scratchy" feeling over the area treated; but in the forty-five years during which I have been using it, no patient has ever been burned, blistered or scratched through its application. Before the first treatment of a new patient it is my custom to tell him about these sensations and to allay any fear of burns.

Generation of Syn-Acro Current

Commercial 110V alternating current is passed through two transformers; from the second transformer to condensers and multiple high tension spark gap; and from the other terminals of the condensers to a solenoid, from which the unipolar therapeutic current is delivered. There are no "tubes" in this apparatus.

Application of this current is made directly to the surface of the body, with no intervening clothing, by means of a vacuum or conductor-filled electrode, the former delivering 250 milliamperes; the latter, 300 ma.

These electrodes have a flat surface for application 1¼ or 1½ inch in diameter and are applied with constant

motion wherever deep hyperemia is indicated.

Five to six minutes of application is sufficient to produce hyperemia along the entire length of the spine.

Clinical Results

In 1925 the General Electric Company cooperated with me in conducting research, at their Schenectady Plant, on the results of this treatment in cases of hay fever. They provided space at the Works Hospital, a nurse to assist in giving treatments and a secretary; and permitted the patients to come for treatment on the Company's time.

This research was started on July 15th and continued until the 4th of October. During that time one hundred and fifty came for treatment but some discontinued of their own volition, but we have a record of 132 who were adequately treated, 49 of whom had asthma as one of the seasonal symptoms. All were treated three times a week, on alternate days, with the exception of those who had severe asthma; these were treated daily until this symptom was decidedly improved, which usually required less than two weeks, after which they were treated thrice weekly.

Of the 132 cases that were sufficiently treated, all but 12 were benefitted, 40 to 100 per cent of their symptoms were alleviated and fewer work hours were lost because of hay fever, than in previous years.

Of the 49 who had asthma as one of the seasonal symptoms, 2 showed no improvement; 47 showed marked improvement, from 40 per cent to 100 per cent.

Two years later, after the end of the hay fever season, letters were sent to all of these patients, asking as to their condition as to hay fever during the two following seasons, 1926 and 1927. Replies were received from 68, from which we learned that slightly over 50 per cent had had no return of hay fever after the one season's treatment in 1925.

Of the 12 who had not been benefitted in 1925, six responded. One reported the same degree of hay fever as in previous years. The other five reported great lessening of their symptoms during the seasons of '26 and '27.

Explanation

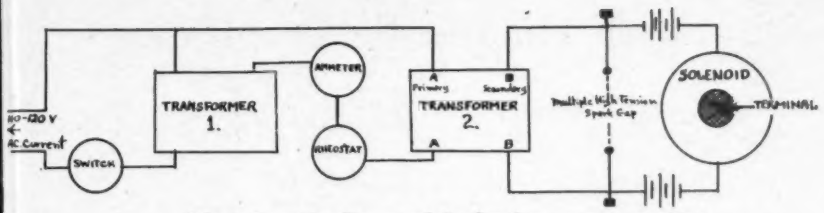
The sympathetic nervous system controls all of the functions of the body. First, through its control of all the secretory epithelium — of the mucous surfaces, of the duct glands and of the ductless glands; Second: through its control of the unstriated, the involuntary, muscles of the body.

With these facts in mind, it is understandable that all the symptoms of asthma could arise from improper functioning of the sympathetic, as well as the so-called allergies. The spasm of the bronchioles, causing the difficulty and distress in respiration; the excessive secretion, with its profuse expectoration, or the scanty secretion with its dry, unproductive cough; the allergies, arising from improper secretion from the glands of digestion, resulting in faulty digestion of this or that food, according to the particular gland or glands affected, with the production and absorption of toxins: the frequent involvement of the thyroid; the rapidity or the irregularity of the heart, and all the other secondary symptoms that accompany asthma.

The conditions mentioned as kindred to asthma, that exist without asthma, owe their origin to the effects of the dysfunctioning sympathetic on other glands and other involuntary muscles. This is evidenced in families where there is an hereditary tendency to sympathetic dysfunctioning, where different members are afflicted with greatly varying conditions, all due to the same basic cause.

One factor that points directly to this basic cause of asthma is the fact that all of the drugs that are employed for the temporary relief of the asthmatic spasm — adrenalin, ephedrin, morphine, atropine—owe their effectiveness to their influence on the sympathetic nerve system.

My one hope is that I may see an investigation of this method of treatment



Schematic wiring diagram of the Syn-Acro current generator

under critical medical observation. This will, I am confident, lead to acknowledgment of its efficacy as a means of relieving asthma and kindred conditions and its adoption as a recognized procedure in medicine.

Conclusion

The results of the treatment of bronchial asthma according to the theories of allergy, and all other methods of treatment, have been disappointing and generally futile.

Treatment by the Syn-Acro Method has resulted in complete and permanent relief to over 60 per cent of those treated and material improvement in an additional 30 per cent.

The records of the cases of hay fever treated at the General Electric Works in 1925 are available for inspection. These records are based on the opinions of the patients, their closest associates and those who treated them.

Communications from most of the organizations that refused to investigate after they had been requested to do so are on file and available for inspection.

845 West End Ave.

Advice to the Prospective Researcher: How Successful Research Is Conducted

It is practically impossible to convince students starting on research that such work is not for heaven-sent geniuses only. There is no doubt that successful research-workers tend to convey this impression to the outsider, because they follow the invariable scientific practice of writing their papers backwards, so to speak. When a research is finally published, it appears to the reader as an orderly series of steps carefully thought out; and if the reader is not already in the trade, the effect is to produce an acute inferiority complex in his mind and to persuade him that in no circumstances would he ever be able to conduct research.

My object in this lecture has been to show that research is never done as it is written, and that the cold orderly paper is produced practically always by a series of blundering steps in which the research-worker is rather like someone in a dark room scrambling for the switch and tripping over the furniture. When he has once found the switch and turned on the light, he can arrange the furniture in an orderly manner.

I think the justifiable conclusion is to go into the laboratory and start work on something which interests you, refusing to be daunted by the great discoveries that have gone before. Success depends mainly on th amount of work that is done in the laboratory; and, though you may not sùcceed in discovering what you set out to find, you can see from the account I have given that you will always discover something.—E. C. Dodds, Courtauld Professor of Biochemistry, University of London, *The Lancet* (London), May 24, 1947.

Some Diagnostic Points on Hepatic Disease

Compiled by C. D. MARPLE, M.D., *New York, New York*

In carcinoma of the liver, a rapid onset of ascites and the rapid development of liver insufficiency suggests marked involvement of the portal vein.

A leukopenia is characteristically found in cases of cirrhosis of the liver.

Although amebic abscess of the liver or amebic hepatitis are not uncommonly encountered, the rather rare echinococcus cyst of the liver should be thought of in connection with possible parasitic infections of that organ.

A common complication of acute suppurative processes in the abdomen, e.g., appendicitis, diverticulitis, is pylephlebitis with liver abscesses and often metastatic abscesses throughout the body.

A history of intermittent abdominal pain usually accompanied by vomiting, epigastric or right upper quadrant in origin, accompanied by fever and leukocytosis and with physical evidence of infection in the right upper quadrant suggests an acute suppurative process in the gall bladder, biliary ducts, or both. Obstruction of the common duct, by stone, may lead to cholangitis, which, if prolonged, may produce the classical pathological picture of biliary cirrhosis.

Elevation of the non-protein nitrogen (NPN) in liver and biliary tract disease may be due to renal tubular damage frequently found in chronic jaundice. In severe liver disease with shock, the NPN may be elevated secondary to anuria.

In advanced syphilis, e.g., cardiovascular syphilis, look for the enlargement and irregular nodularity of the liver indicative of hepar lobatum. In the presence of lues, an increase in the globulin portion of the blood proteins may indicate liver damage, or may be due to the syphilis (or may be a normal finding in Negroes).

All patients who exhibit chronic jaundice for which no cause can be found should be explored before the stage of hepatic insufficiency. Peritoneoscopy is a poor substitute if for no other reason that many common duct stones are missed by this procedure.

Five to 10 per cent of patients with common duct obstruction do not have pain.

A low blood sugar is a characteristic finding in acute necrosis of the liver and the presence of an elevated serum amylase suggests that pancreatic necrosis is also present.

Cases of Laennec's cirrhosis of the liver (portal cirrhosis) may become severely ill and die without presenting any of the clinical features commonly seen in the disease, such as ascites and peripheral edema. In brief, they may succumb to the cirrhosis before portal insufficiency has an opportunity to develop.

Elevation of the NPN is seen in all massive gastro-intestinal hemorrhages and is due to the actual absorption of non-protein nitrogenous substances from the blood in the gastro-intestinal tract.

In the presence of ascites of undetermined or unproven etiology, paracentesis fluid should be centrifuged, the sediment smeared, stained and examined for malignant cells which may often be readily demonstrated.

Problems in Practice

Ether Anesthesia in Hot Climate

Question: How may ether be safely given in a hot, tropical type climate?—M.D., Louisiana.

Answer: The attached illustration is the suggestion of M. P. C. STORNI, M.D., Fellow in Anesthesiology at the Mayo Clinic and published in *Anesthesiology*, July 1944. Because the ether can is below the level of the nose, the patient cannot inhale liquid ether. The patient's eyes are protected with moist cotton, fixed in place with adhesive tape. As the ether in the can becomes warm, the vapor is forced through the tube by expansion.

(A simple method is to pierce the soft top of the can with a pin, then to spray a fine stream of ether on the mask, keeping it constantly moving so as to avoid soaking the mask.—Ed.)

Fig. 1. Method of holding ether can, with free end of rubber tube under the mask.

Indolent Ulcers and Bed Sores

Question: What is a home and office method of treating ulcers or bed sores that are slow to heal?—M.D., San Diego, Calif.

Answer: Ulcers that are slow to heal and bed sores, may be encouraged to heal by repeated, *mild* applications of ultra-violet rays (University of Minnesota Hospitals).

Recent literature emphasizes the importance of a high protein diet, the possibilities of immediate cure by removal of the ulcer and prompt skin grafting, the advisability of administering all vitamins. Bed sores (decubitus ulcers) are usually due to constant pressure of a bony area on unpadded skin; this must be avoided by rubber rings, rubber foam mattresses or other means. Application of scarlet red ointment stimulates healing, if other conditions are favorable. Either bed sores or ulcers of the leg tend to heal if steady compression is made with elastic adhesive tape, across the ulcer.

Scrubbing the Hands

Question: How effective is scrubbing the hands, as far as sterilization is concerned?

Answer: The bacteriology department of the University of Minnesota Medical School stated "Hands may be sterilized by use of soap and *running* water, which removes 98 percent of bacteria, followed by an alcohol rinse. If scrubbing is carried on for 10 minutes, one may be sure that the hands are reasonably sterile. If a glove is torn during the course of an operation or delivery, it is only necessary to rinse with alcohol and don a fresh glove."

Pruritus Ani

Question: What is a simple local application for itching around the anus?—M.D., Ainsworth, Nebraska.

Answer: Many cases of anal itching get relief, and even cure, from simply washing the anus with water-soaked cotton or toilet paper after each bowel movement.

A simple method of therapy is the painting of the anal area with this prescription, after drying the anus:

Coal tar
Collodion
Acetone ãã

(University of Minnesota hospital, proctology section). Scratching and further aggravation of the itching is prevented by the protecting layer of collodion.

EDITORIALS

The Psychological Moment in the Treatment of Disease

IN THE National Tuberculosis Association, *Tuberculosis Abstracts,* for December 1946, there is striking editorial that tells the physician how he should manage the patient at the time of informing him of the finding of a severe illness. While this material refers to tuberculosis, it can also be used with reference to a diagnosis of heart disease, diabetes, pernicious anemia, and other serious conditions—either acute or chronic. It is at this moment that the patient is most impressed with the importance and seriousness of his illness. If the physician will only take time to explain at that moment what the disease is, in simple terms, and why it must be managed either by medical or surgical methods, the patient will understand fully and comprehend more readily.

The important portions of the abstract are reproduced here.

This human being who comes with his questions and his needs to the physician requires first of all, a diagnosis —that is a recognition and an evaluation of his physical state. Diagnosis may be difficult or easy. But even as the symptoms are being elicited, the physician is already seeking the facts and making the observations which will guide him when he acquaints the patient with the situation and prepares him for whatever treatment is necessary. It is then that the doctor functions primarily as a teacher and a friend.

The time at which the physician acquaints the patient with his diagnosis, especially when it is that of a chronic disease such as tuberculosis, is a teachable moment. It is then that the fearful patient listens intently in order that no word of the physician, no implication of his tone or manner will escape notice or be given less than its true importance. It is often, at this time, that the foundation is laid for a successful recovery from tuberculosis. Sometimes, unfortunately, the opportunity is wasted, with disastrous consequences.

To assemble the facts, to weigh the possibilities, to help the patient face the reality and to be ready with constructive plans, calls for great skill on the part of the physician. He must make sure that the implications of the diagnosis are understood, yet he must be as optimistic as the facts warrant. He must stress the necessity for a drastic change in the life and plans of the patient, yet never proceed faster than the patient is ready to go along with him in his thinking.

If handled hurriedly or casually, the patient may refuse to accept the diagnosis; he may delay or postpone the treatment; or he may undertake his cure in so rebellious or apathetic a spirit that he nullifies the best efforts of the hospital and medical staff. What happens to an individual tuberculosis patient is often determined by the attitudes and teaching of the physician who makes the first diagnosis. It is then that treatment really begins. In tuberculosis the sequence of diagnosis, treatment and rehabilitation should always overlap and be woven together as a well-spliced rope.

What is the duty of the physician to the man or woman on whom he makes a diagnosis of pulmonary tuberculosis. It depends on his findings in the indi-

vidual case. If the patient has active tuberculosis, it should be discussed as a communicable disease. With full consideration for the patient's intelligence and temperament, the physician should tell the patient that he has tuberculosis. He should not overestimate nor underestimate; he should give the patient the facts as he then sees them.

It is quite possible, by properly taken stereoscopic pictures, to determine almost exactly how much tuberculosis the patient has. It is quite impossible by X-ray pictures alone to establish the degree of clinical activity, perhaps the most important aspect of the prognosis. The patient should be told that only after consideration of clinical and laboratory findings, of constitutional symptoms, and of his response to treatment as shown by the X-ray can any estimate of the length of time required for treatment be made.

Time does not usually permit the physician who makes the diagnosis to educate the patient in matters of tuberculosis. *He should, however, never dismiss the patient without making sure that he has accepted the necessity for treatment.* Until this acceptance is obtained, progress along other lines should not be attempted. This may take time, and the help of the public health nurse and the social worker. A confirmatory diagnosis by a tuberculosis specialist may be required. But until hospital treatment is initiated the patient is under the care of the physician who made the diagnosis. The responsibility for sound and careful guidance, for the protection of the family and for interim treatment rests with him.

Once the patient is in the sanatorium, he is the responsibility of the sanatorium physician who becomes his patient's instructor in health problems. Only as the patient understands the character of the disease that he is fighting will he know why it is necessary for him to follow closely a definite program, foregoing seemingly harmless pleasures and avoiding undue activity.

An understanding of the tuberculosis hospital will help the private physician in preparing his patient for treatment there. It will also enable him to give more effective counsel when the patient returns from the hospital. The need of periodic check-ups persists in all "cured" cases of tuberculosis even after economic independence and normal life has been attained.

The patient whose cooperation is enlisted at the time of the diagnosis is apt to become a good hospital patient. Moreover, such patients usually not only do better under treatment but are more successful in staying well after discharge. The foundation for successful treatment in tuberculosis is laid when the doctor tells the patient that he has the disease. Psychologically, medically and economically, this may well prove to be the biggest moment in the patient's life—J. D. RILEY, M.D., *American Review of Tuberculosis*, Oct.-Nov., 1946.

How to Be Happy Though Practicing

HAPPINESS is postive or negative. Negative happiness, or the avoidance of unhappiness, is the philosophy of the wise men of India. One should not want too much. This is opposed to civilization which encourages artificial desires.

Don't long for things that are impossible in your situation—but don't be afraid to change anything to increase you happiness or your ability to work more efficiently.

Don't say, "I wish that I didn't have evening office hours." Look over your

records to learn how many persons come to your office at night and to learn how many could just as well come in during the day. You may learn that the great majority could make the call earlier. A few patients will be lost, if you make the change, but so what? We are talking about happiness, not income. You cannot have big portions of both.

Don't say, "I wish that I didn't have to make night calls." This is an inseparable part of good practice. The physician who does not make night calls in the home or hospital is not truly interested in his patients or in medicine, or he would wish to help the one and advance the other. Symptoms or signs may appear for the first, or only, time at night. Any physician, regardless of specialty, must care for his patients in emergencies. If he thinks first of his own comfort, let him sell potatoes. He doesn't belong in a profession in which life and health are at stake.

An Army Ph.D. Observes Army M.D.'s

By RUSSELL B. STEVENS, Ph.D.

There appeared a few years ago, in the *New Yorker* I think, a cartoon showing a uniformed maid in what might well have been the home of a college professor. She was apparently answering on the phone a query as to whether that was the residence of a Dr.———. To this she replied: "Yes, Dr.———— lives here, but he ain't the kind of a doctor that does anybody any good." It is as just such a despised layman, and from the comparative security of newly achieved civilian status, that I venture the following remarks.

The "Army Doctor"

Speaking of cartoons, no subject was more joyfully seized upon by wartime artists and joke writers than the "Army doctor"; his every ministration to the luckless soldier from the introductory physical examination to the final discharge examination receiving caustic comment. Granted that most of the ridicule was exaggerated and much of it downright untrue; was not its considerable success as humor predicated upon a certain basis in fact?

We should remember further that the so-called Army doctor was in reality usually a practicing physician, transplanted abruptly from civilian life to military duties, and owing only temporary allegiance to the services. If there was a measure of justice in the criticisms of the Army physician, then these criticisms may perhaps fairly be leveled at the civilian doctor as well. It seems hardly likely that an individual would show during a limited period qualities which neither existed previously nor persisted thereafter. (Why not? He was under entirely different temporary conditions.—Ed.)

It is not the purpose of this note to dwell upon those familiar facets of the medical officer which most frequently engaged the attention of the humorists. To a very large degree the superficialities evident in physical examinations were the unavoidable result of demands made upon understaffed units for speed and large scale output. Again, much of the apparent negligence toward minor ills was excusable in the light of the demands of more serious cases. Some further discount must be reckoned for the belief especially widespread among soldiers that any thing or person in the Army, doctors not excepted, is to be criticized

by virtue of the simple fact that it is the Army.

Is the Physician Scientific?

There remains one attribute of the physician which I believe merits serious attention; his failure to maintain that disinterested, inquisitive attitude so fundamentally a part of the scientific method. For nearly four years it was my duty, and, in many senses a privilege, to serve with the Medical Department of the Army, in virtually every rank from private to first lieutenant, and in more than a handful of different capacities.

The greater portion of this time was spent as a Sanitary Corps officer directing the clinical laboratory of a Southwest Pacific hospital. In all, I have worked in close collaboration with more than half a hundred medical officers, surely a fair sample geographically and professionally of the present day American doctor. Needless to say, a military campaign in the tropics imposes particular burdens upon both doctor and clinical laboratory worker, and presents problems which cannot have been fully covered in the previous studies of either. Yet it was my experience that the physician reacts to such a situation in a manner wholly out of keeping with that expected of the trained scientific man.

Accustomed to the methods and attitude of the university biologist, this evident dogmatism came as a distinct disappointment. Where the parasitologist, the chemist, or the bacteriologist inclines toward unbiased investigation of an unanswered question, the medical practitioner all too frequently demonstrates a tendency to force data toward a preformed diagnosis, a stubborn disregard of conflicting facts and a profound lack of interest in new ones, coupled with a marked personal sensitivity to opposing viewpoints. While a certain assurance of manner is indispensable to insure the confidence of the patient, need this develop into an attitude of complacency, and more particularly need this attitude be carried into the clinical laboratory itself?

One is led to ask at just what point the developing physician turns from objective investigation toward dogmatism. From experience in teaching I am convinced that as an undergraduate the future doctor cannot be distinguished from the future research scientist. Having worked intimately with both I am equally convinced that the medical practitioner has lost to his own hurt a scientific curiosity which the teacher or investigator has very largely retained. Surely our medical schools are open to criticism if they foster in their graduates a feeling of complacency over the scanty information accumulated during medical school years. This is after all an attitude which will in any event be more than sufficiently nurtured by the worshipful attitude of the public during the subsequent years of practice. The Army doctor by no means wholly deserves the reputation he has gained in the services, but in such measure as he is guilty of the limitations noted above, he has brought it upon himself.

Christmas Greetings to One and All of the Increasing Family of Clinical Medicine Readers.

— CLINICAL MEDICINE STAFF

Excision of Vas Deferens

Question: What is a simple office technique for ligating or excising a portion of the vas to produce permanent sterility in a male patient? R.S., M.D., New York City.

R. L. Dickinson, M.D. described a method employed in many hundreds of cases in California (*J.A.M.A.*, 92, 373, 1929) using either general or local anesthesia. The accompanying illustrations were made for *Clinical Medicine* by a staff artist.

A. E. Belt (*J.A.M.A.*, 102, 396, 1934) states that live spermatozoa are found in the ejaculate for 28 days. During this time a rubber condom should be used, during intercourse.

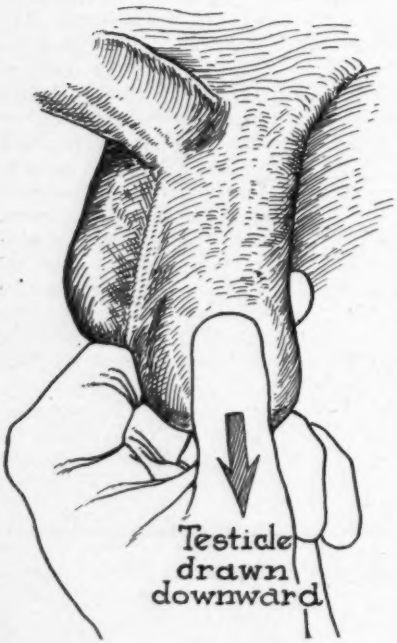


Fig. 1. To put tension on the vas and make it more readily palpable, the testicle is pulled down.

Fig. 2. The whole spermatic cord is thus lifted up and grasped with the thumb and index finger of each hand. It is a firm, cord like structure.

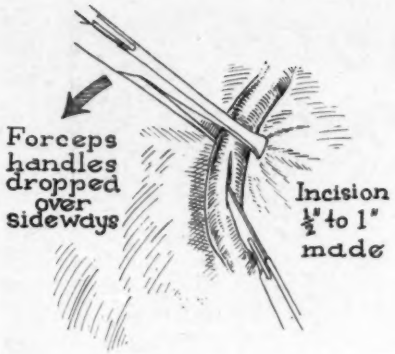


Fig. 3. Procaine solution is injected into the skin over the cord and surrounding scrotum and the cord is held up with Allis forceps which grasp it through the skin. An incision is made of ½ to 1 inches in length.

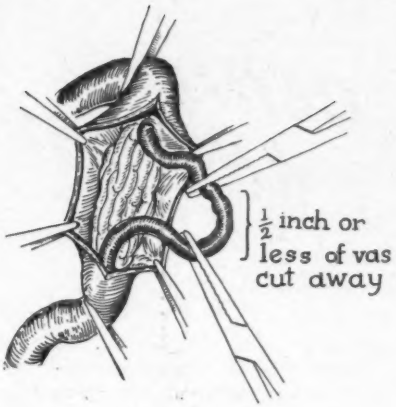


Fig. 4. A loop of vas is pulled out, tissues are stripped back with particular attention to the fine artery and veins which lie close to the cord. After dissecting or pushing back the loose tissues, ½ inch or less of the vas is cut away. Even small oozing vessels are ligated with a fine catgut suture on a round needle.

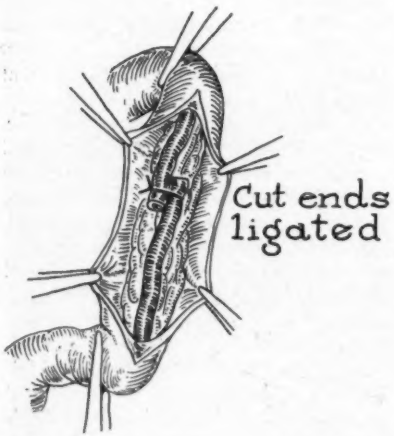


Fig. 5. The ends of the vas are then ligated and the ends overlapped or soft tissues may be sutured in place between the ends. One or two sutures close the wound.

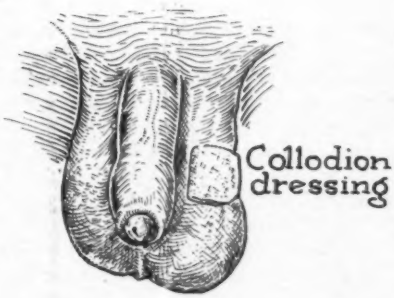


Fig. 6. The wound is collodion sealed and the patient wears a suspensory for 3 days.

CLINICAL NOTES AND ABSTRACTS

Clinical Notes on Cardiology

Three therapeutic measures which are superior to drugs and other remedies in the treatment of heart affections are emotional control, rest and exercise. Usually, people who reach a great age without heart trouble have practiced a high degree of emotional control: they have not permitted themselves to be stampeded by people or circumstances and have not allowed worry to obstruct this emotional control. Rest is a therapeutic agent which those patients who have been driving full speed ahead for many years will usually refuse to take. (E. KEATING, *Illinois Med. Journal*, Nov. 1945).

Curable Heart Disease

That heart disease is often reversible is evidenced in thyrotoxicosis, myxedema, beri-beri, severe anemia, in acute pericardial effusions and in acute hemorrhagic nephritis. It is now further evident that a large per cent of patients who suffer from coronary heart disease, manifested in coronary occlusion or anginal attacks, may survive for many years and that they may do so without symptoms of coronary insufficiency.

Evaluating a Murmur

The following facts should be retained in mind for review when attempting to evaluate any cardiac murmur: (1) All murmurs are not organic, (2) A murmur does not necessarily indicate a diseased heart, (3) The point of maximum intensity of a murmur is not always its place of origin, (4) The audibility of a murmur is dependent on a variety of factors, (5) A valve can be diseased without necessarily producing a typical murmur and, as a corollary, a murmur, apparently typical of a certain type of valvular disease, may exist in the presence of a perfectly normal valve, (6) Severity of disease cannot be judged accurately from the characteristics of the murmurs heard alone, (7) Murmurs and split-heart sounds must be differentiated, (8) Auscultation of the heart should be performed with the patient in various positions and, frequently, both before and following exercise, (9) Cardiac disease and the origin and type of lesion must be evaluated from all clinical and laboratory findings, not from the nature of the murmurs alone.

Radiology assists in clarifying points of confusion in cardiology. Vertical hearts as found in narrow chested persons with low diaphragms and transverse hearts found in the short-necked, broad chested individuals with a high diaphragm present different physical and electrocardiographic pictures which are physiological variations only. For example, in the former patient, T wave inversion in the electrocardiogram will occur in the erect posture; in the latter, the electrocardiogram may show a trend toward left axis deviation.

In the presence of carditis and val-

vulitis, *the particular valvular lesion is of little immediate interest* and the prognosis depends more upon the pulse-rate, blood counts, sedimentation rate and other examinations. A systolic murmur is commonly present, sometimes an apical diastolic murmur. This does not necessarily imply mitral stenosis, but may be due to the myocarditis, in which case the murmur disappears as the acute inflammatory process subsides. A normal third heart sound in childhood can easily be mistaken for a transient apical diastolic murmur. (J. PARKINSON, *Lancet*, November 24, 1945).

Neurocirculatory asthenia is commonly found in constitutionally inferior persons, frequently following a severe illness. A careful history will reveal the unstable personality. Examination will reveal nervousness, tremor of the extremities, bitten nails, large pupils, exaggerated tendon reflexes and frequent sighing respiration.

Cardiac Symptoms Without Heart Disease

The chief symptoms are: (1) Breathlessness on exertion which is characteristically more obvious to the patient than to the observer, (2) Precordial pain of an aching or stabbing type, persistent, occasionally radiating to back, shoulders, arms, or left lateral chest, occurring with or without relation to activity, producing more emotional than physical distress. It is frequently located or originated at the nipple area and not, as in coronary insufficiency, substernally. (3) Palpitation, most apparent under conditions of stress and out of proportion to the physical findings. There is frequently associated an increased sensitiveness to mastoid pressure. (4) Exhaustion, characteristically present upon arising and progressing during the day, (5) Headaches, commonly dull and frontal, worse on exertion, but usually arrhythmical as regards time and circumstance. (6) Variable complaints include faintness, vertigo, excessive sweating, cyanosis, tingling of extremities and other emotional symptoms. (J. BENN, *Med. Bull.*, Oct. 24, 1945)

Bruckner (*Connecticut State Med. J.*, June 1944) points out that true cardiac pain is almost never localized below the left breast and that the typical anginal pain (coronary, too, for that matter) is retrosternal in origin and constricting in character, no matter what its radiation.

A simple basis for the management of coronary occlusion includes four fundamental postulates: (1) Relieve pain with intravenous papaverine, or, if this is ineffective, with morphine, abetted by rest and continuous oxygen, (2) Control shock, (3) Combat regional coronary constriction and (4) Prevent serious complications, including ventricular fibrillation (by quinidine sulphate), pulmonary embolism (prevent with deep breathing and leg exercises) and pulmonary edema (digitalis and O_2).—O. P. J. FALK, *Mississippi Valley Medical J.*, Jan. 1946.

Management of Burns

The local management of burns must include the original cleansing of the burned area by the general use of white soap and water, using wet cotton in the removal of loose tissue. This is a sound surgical principle rather than the use of specific drugs. A burn is an open, surgical wound which is potentially infected. This is accomplished by very careful primary cleansing and thereafter keeping it as clean as possible, and it matters little what is used to accomplish this end. Tannic acid should never be used on the hands, face or genitalia. It may be used in severe burns of the back which seldom need skin graft, but this means that the patient is given a covered surface to lie on. Electrical burn is vastly more destructive to the bone tissue than ordinary heat burn. All burned areas which produce contracture should be skin grafted as soon as they are cleaned. Sulfonamide drugs,

locally or orally, are of no benefit, rather a detriment. Blood transfusions are of more value after the 7th day. Skin grafts from one individual to another, especially close relatives, while never permanently successful are lifesaving in extensive burns.—H. L. D. KIRKHAM, M. D., in *American Jrnl. of Surgery*, Feb., 1947

Dicumarol in the Average General Hospital

Dicumarol should not be used in hospitals where prothrombin time determinations cannot be made. Catastrophies have occurred when no prothrombin time determinations were made. In fact, in some clinics, even when such determination was made, the lack of careful standardization of reagent used in these tests has resulted in serious hemorrhages and even death. Hence the average general hospital, and indeed even some of the larger clinics, are not at the present time in a position to adequately and safely supervise the administration of this drug.—H. RAYMOND PETERS, M.D., Baltimore, Md.

(This letter is written in respo se to a letter written by the Editor of Clinical Medicine in regard to the use of Dicumarol in acute coronary thrombosis. Apparently this author has found that dicumarol is of value in the treatment of acute coronary thrombosis. Because of limitations of technicians and laboratory help, this advance will probably not be utilizable by the average physician for some time to come.—Ed.)

Estrogenic Therapy in Women

There is an increasing abundance of evidence against exposing women to constant estrogenic stimulation. At the height of the period of ovarian activity in a woman's life, excluding pregnancy, she is under the stimulation of estrogen for only about three weeks out of every four. The use of constant estrogen therapy produces functional uterine bleeding, endometrial hyperplasia and mammary changes in an appreciable number of women. It is concluded that estrogenic therapy in general should be periodic and that rest periods should be provided. — C. D. MARPLE, M. D.

Deflation Before Intestinal Resection

Prior to resection of the colon, a Miller-Abbot tube is put down into the stomach and intestinal tract 48 hours prior to operation, and the entire small bowel telescoped over the tube into a small mass. During the operation, this mass can be placed on the left side while operating on the right colon or placed far over in the right side of the abdominal cavity when operating on the left colon. HENRY CAVE, M.D. in "The Doctors Talk It Over" (Lederle Laboratories).

Too few surgeons routinely insert a duodenal tube with continous suction prior to all abdominal operations. The bowel deflation permits better vision and more room to work.—Ed.

Thiamine (B_1) During Labor

The intramuscular administration of 60 mg. of thiamine hydrochloride (vitamin B_1) results in an acceleration of labor and in some relief of pain. Intravenous administration results in a rapid but very short pain relief. Supplementary doses of 60 mg. may be given.—PROFESSOR R. SCHUB, Central Institute of Gynecology and Obstetrics, Leningrad, Russia.

Treatment of Trichomonas Vaginitis

A simple treatment for Trichomonas vaginitis consists of vaginal douches with half a percent (½%) of zinc chloride solution twice a day for one week and once a day for another week. The solution may be dispensed as 5 Gms. zinc chloride dissolved in 150 cc. distilled water and a tablespoon of this solution is added to a quart of lukewarm water at the time of douching. Douches may be replaced by daily swabbing of the vagina by the physician. Sexual relations are forbidden during treatment and recurrences should focus suspicion that the patient is having intercourse with a Trichomonas carrier. There is subjective improvement within two days and the Trichomonads disappear shortly thereafter.—J. NOVAK, *Urol. &Cut. Rev.*, 50, 80, 1946.

Effect of Weight Reduction on Hypertension

David Adlersberg, et. al. (*Jour. Mt. Sinai Hosp.*, 12, 984, 1946) observed the effect of weight reduction on the course of arterial hypertension in a group of 54 obese persons without clinical signs of heart failure, renal disease or myocardial damage.

Treatment consisted of a 1200 calorie diet, adequate in protein, vitamins and minerals, and nothing more; no medication, thyroid and dehydration was used.

The average course of treatment was about 8 months, the average weight loss 23.5 pounds and there was an associated decrease in the blood pressure in 72% of the patients. Fifteen patients were examined after 3 years at which time the course of the hypertension appeared more favorable in those patients who had maintained the reduced weight than among those who had increased in weight during the interval. No matter what the response in weight and blood pressure, vascular changes in the fundi remained unaltered.

Heparin Treatment of Gangrene

The intravenous injection of heparin in isotonic sodium chloride and Ringer's solution may restore circulation in a slowly developing gangrene of the extremity and gradual return of viability. Clinical gangrene was averted in a case of comminuted fracture of the tibia extending to the ankle joint. Treatment included intermittent venous occlusion and administration of papaverine and heparin (4.625 gm.) and 12,000 cc. sodium chloride in Ringer's solutions. — J. McLEAN M.D., in *Surgery*, September 1946.

Cirrhosis of the Liver

Administration of methionine 2 Gm. daily, choline chloride 2 Gm. daily, very high protein, low fat and moderate carbohydrate diet, aqueous liver extract containing vitamin B complex, and frequent feedings of skimmed milk, resulted in marked improvement in patients with cirrhosis, with or without ascites. Aqueous liver extract is given daily for several weeks in 5cc doses, then gradually decreased. — LESTER MORRISON, M. D., in *J.A.M.A.*, June 21, 1947.

Corns

Dr. M. P. Ranjau says that a piece of lint soaked in vinegar tied around the corn will secure rest at night. The central core should be destroyed by touching it with glacial acetic acid applied on a match stick twice daily, or nitric acid may be used instead. A good corn solvent is:

Rx	Acid. Salicyl.	grs. x
	Extr. Cannab. Ind.	grs. x
	Colloid. Flexil.	drs. v
	Aetheris	drs. II

M. Ft Pigm.

Sig. Apply, and remove the central core after a few days. *Medical World*, (England) Sept. 6, 1946.

The Significance of Rising Blood Pressures as Shown by Periodic Examinations

A rise in the diastolic pressure followed by a rise in the systolic pressure when making periodic health or industrial examinations suggests that the patient is developing an essential hypertension because of nutritional failure which may be caused by any one or any combination of the following factors:

1. Nutrition improper as to quanitity, quality, timing or vitamin content.
2. Exposure to low concentrations of chemicals used in industry.
3. Improper and self medication with sulfa drugs, aniline derivitives or alcoholic beverages.
4. Disease which is essentially chemical posioning.
5. Fatigue or exhaustion due to mental or physical overexertion.
6. Exposure to cold, to sudden changes of altitude or shipwreck.
7. Deprivation of oxygen for any reason.

Search for and removal of any of these possible etiological factors soon after the blood pressure rise is first noted, will prevent the establishment of essential or malignant hypertension and hypertensive cardiovascular renal disease.

A lack of vitamins C, riboflavin and other as yet unidentified portions of the B complex in the diet may be the cause of the hypertensive syndromes. They are among the most common of the vitamin deficiencies. —N. S. DAVIS, III, M.D., 700 North Michigan Ave., Chicago, Ill.

Contrast Baths for Arthritis

The use of contrast baths is very helpful in rheumatoid arthritis. The patient immerses the hands or feet in hot water (105 to 110° F. depending upon the adequacy of circulation and sensation of the extremity) for 10 minutes, then in cold water (50 to 60° F.) for 1 minute following which it is placed alternately in hot water for 4 minutes and cold water for 1 minute. The alternation is repeated three or four times, always ending in hot water. Such treatments are carried out twice daily, with a duration of 25 minutes apiece.—H. F. Polley, M.D. in *Southern Med. J.*, July 1947.

Aminoacids for Mysathenia Gravis

The intravenous injection of pure aminoacids temporarily relieves the extreme muscle weakness of patients with myasthenia gravis and their muscles respond like those of a normal person to electrical stimulation.—Harold G. Wolff, M.D.and Clara Torda, M.D., Cornell University School of Medicine, 525 E. 68th Street, New York City.

Thyroid for Migraine

Thyroid extract relieves the severe swelling and intracranial pressure of migraine headaches. Many migraine patients are hypothyroid. — B. O. Barnes, M.D., Kingman, Arizona.

Ultraviolet Therapy for Alopecia Areata

Ultraviolet radiation is of value in treating alopecia areata. In many cases, there is stimulation for hair to grow. —*The Burdick Syllabus*, February 1947.

Penicillin in Agranulocytosis

Pencillin is the drug of choice in the treatment of agranulocytosis or sepsis complicating agranulocytosis and the use of any of the sulphonamides is not indicated. Pencillin alone should prove as effective as when used with agents to stimulate the bone marrow.—W. E. Herrel, *Proc. Staff. Meet., Mayo Clinic*, 21: 197, May 15, 1946.

Angina Pectoris

Surgical removal or alcohol injection of the second, third and fourth thoracic sympathetic ganglions on the affected side should cause a complete alleviation of anginal pain and a reduction of coronary vasospasm.—Roland M. Klemme, M.D. in *Ann. Surg.*, Jan. 1947.

Estrogens for Senile Vaginitis

Estrogenic substances (Theelin, stilbestrol) relieve the burning discomfort and urinary frequency of older women with associated senile vaginitis.—*South Med. & Surg.*, July 1947.

Oxidized Cellulose Gauze Packing for Epistaxis

Oxidized cellulose gauze packing may be left in the nose to control nosebleed. It need not be removed as it will disintegrate in 48 hours into a jelly-like mass that comes away without instrumentation. It is inserted in sufficient quantity and with sufficient pressure to control bleeding. The packing is hemostatic and absorbale. It is useful for nasal bleeding secondary to traumatic, surgical or spontaneous hemorrhages. —Karl M. Houser, M.D. in *J.A.M.A.*,

Diagnostic Points in Pancreatic Carcinoma

Pain, usually in the back, occurs in 86% of patients with carcinoma of the pancreas. The pain may simulate cholecystitis or can radiate to various regions of the trunk. Patients may obtain relief only by assuming bizarre positions. Pain in the back, made worse by stretching, is a feature of many cases of carcinoma of the body of the pancreas. Intractable pain in cases of carcinoma of the pancreas is attributed to infiltration of nerve sheaths by malignant cells.

Carcinoma of the pancreas may extend directly to involve the wall of the stomach and so produce bleeding

Treatment of Pernicious Anemia

One may give as much as 70 units to very anemic patients in a single dose, then 30 units weekly until the patient's red cell count is over 5,000,000. The 30 unit doses are then spaced out, possibly as far apart as 4 weeks.—WYMAN RICHARDSON, M.D. in *Amer. Pract.*, June, 1947.

"Gushing" Vaginal Bleeding

Gushing vaginal bleeding is characteristic of four affections: 1. Abortion; 2. Cancer; 3. Submucous fibroids; 4. Cases of disturbed ovarian function with palpable ovarian lesions, mostly in association with fibroids.—G. D. ROYSTON, M.D. in *J. Iowa S. M. Soc.*, June 1947.

Convulsions in Infants

Epilepsy, acute infections, meningitis and brain tumors account for almost three-fourths of all cases of convulsions in infants and children.—"Health Instruction Yearbook" (Stanford University Press).

Use of Thyroid in Gynecology

When given in combination with iron, it is often quite dramatically effective in cases of either primary or secondary amenorrhea. This is particularly the case when the amenorrhea is met with in an adipose subject. Thyroid extract is also sometimes beneficial in cases of functional hemorrhage.—*Medical World, England*, June 13, 1947.

Treatment of Cerebral Degeneration

Cerebral and cerebellar degeneration may be improved by sympathetic nervous system interruption (stellate ganglion blocks, stellate ganglionectomy, upper thoracic anterior rhizotomy).—W. JAMES GARDNER, M.D. in *Cleveland Clinic Quarterly*, April 1947.

Shock

Shock is a failure of the circulation. Fall of blood pressure follows rather than initiates the onset of shock. It occurs only when the compensatory mechanism of the body commences to break down.—HAMILTON BAILEY, F.R.C.S. in "Surgery of Modern Warfare." (Williams and Wilkins Company).

Prevention of Pulmonary Embolism

Early walking of patients following operation or illness prevents venous stasis, thrombosis and embolism. 5,000 operations were performed (Naval Hospital, St. Albans, N.Y.) in all age groups without a single pulmonary embolus. The patients were out of bed the day following operation in almost every instance.—GERALD H. PRATT, M. D. in *N.Y.S.J.M.*, Aug. 15, 1946.

A Textbook of Medicine

Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine, Cornell University Medical College, New York City, Walsh McDermott, M.D., Associate Professor of Medicine, and Harold G. Wolff, M.D., Associate Professor of Neurology. —W. B. Saunders Co. $10.00.

A series of short papers on every topic in the field of internal medicine by recognized authorities make this an ideal textbook for student and practitioner. Illustrations are included and are helpful, but many more could be used. A survey of the work shows that recent advances have been incorporated. Those of us who have used successive editions always reach first for "Cecil."

Rehabilitation Through Better Nutrition

By Tom D. Spies, M.D., Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. W. B. Sauders Co. 1947. $4.00.

The author portrays through case histories and colored illustrations the improper diets that make people sick and the proper methods of treatment to make them well. Almost any physician, in glancing over this little book, will recollect one or more patients who did not do well and who were no doubt taking an inadequate diet. This is recommended reading for any physician. It must be remembered that some persons are nutritionally deficient because of a diet prescribed by a physician in the treatment of ulcer or other condition.

Minor Surgery

By Charles M. Oman, M.D., Rear Admiral, (M.C.) U.S. Navy. Commanding Officer, Naval Medical Center, Washington, D.C.—Oxford University Press. $2.00.

This didactic exposition of minor surgery seems less useful than the other Oxford outline series texts because it is difficult to grasp anatomy and surgical technic without illustrations. The author gives a conservative presentation omitting many valuable advances such as the procaine treatment of ankle sprains. His warning that patients must remain quiet for 24 hours after lumbar puncture is in error. The book may be of value to medical students.

Varicose Veins and Hemorrhoids

By H. O. McPheeters, M.D., Formerly Director of Vericose Vein and Ulcer Clinic, Minneapolis General Hospital, and James K. Anderson, M.D., Clinical Associate Professor of Surgery, University of Minnesota.—F. A. Davis. 1946. $5.00.

McPheeters long since popularized the ambulatory treatment of varicose ulcers wth elastic compression (rubber sponge and elastic bandage). Those who have not seen the spectacular results from this simple therapy find them hard to believe. The whole section is very worthwhile for the physician who treats varicosities in any location. The material on hemorrhoids is well organized, clear and eminently practical also.

Diseases of Children

Lectures on Diseases of Children. By Sir Robert Hutchinson, Bart., M.D., and Alan Moncrief, M.D., Hospital for Sick Children, Great Ormond Street, London.—Edward Arnold & Co., London, England. $6.75.

A series of practical talks by a master teacher on the normal and the ill child. Common sense admonitions prevail as to the wide range of normal; what is normal in the child as opposed to the normal in the adult; how to detect differences on physical examination and what they signify; how much importance to attach to so-called pathognomic signs; what to feed the infant and so on. The authors do not use long or vague terms to cover vague concepts. This is an interesting volume to read in spare moments.

Penicillin Therapy

Including Streptomycin, Tyrothricin and other Antibiotics. By John Kolmer, M.D., Professor of Medicine, Temple University Medical School, Philadelphia.—D. Appleton-Century Co. 1947. $6.00.

The second edition of Kolmer's book on penicillin treatment is even more complete and useful than the first, furnishing sufficient information for the average laboratory to aid in the management of patients requiring extended therapy and information for the clinician as to clinical management of those conditions that will be benefited by each type of antibiotic therapy. Exact details of treatment are given.

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Key to Abbreviations: (ab) Abstract; (dp) Diagnostic Pointers; (ed) Editorial; (rev) Book Review; (tt) Thumbnail Therapeutics: (gc) Graduate Course; (cn) Clinical Note; (ps) Pictorial Section.

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